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Research Paper

Psychosocial adjustment of a child in an institutional care with atypical gender identity development

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ABSTRACT

Adolescence is a phase of significant upheaval in any child's life. It is more so in this 11-year-old case. Living in institutions implies shared living spaces with many with hardly any personal space to understand and absorb the complex changes happening to her (gender the individual identifies as now). The case study here, attempts to throw light on the complex biological-physical, cognitive, social, and emotional developmental dimensions the child faces. The nature of this study is to bring out the incongruent gender identity of the child diagnosed with gender dysphoria. The emotional distress and confusion experienced when shifted from familiar surroundings to a new place, especially with pubertal physical changes. The feelings of dysphoria and gender identity issues manifest differently, so different coping skills are very much needed to equip the child in this challenging transformation. The environmental factors such as the primary caregivers, peers, school and media influence the individual in building gender-based attitudes, behaviours and beliefs. The problems faced by the individual concerning the adjustments to make with self, the caregivers and peer need to be addressed. Although gender nonconformity is not a mental disorder, Gender Dysphoria is characterised by clinically significant mental anguish. Persons with Gender Dysphoria often have impaired social and occupational functioning because of the marked difference between their expressed gender and their gender at birth. A provisional support system that encourages the individual self-understanding and better mind-body connections through this self-evolution phase is the key to building self-esteem in these children.

Keywords: *Adolescence, Gender Dysphoria, Emotional distress, Social acceptance*

Adolescence is a phase of significant upheaval in any child's life. Children or adolescents who experience gender confusion cannot associate to the expression of the gender which they identify within traditional societal binary male or female roles, which may cause cultural stigmatisation. Individual identity is a complex reflection of a person's gender, nationality, language, academic, occupational pursuits and religious beliefs. It defines how one understands, describes and expresses self and is reflected in all aspects of life.

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In India, prenatal gender identification is illegal (since1994) due to female foeticide; children are assigned gender at birth based on the physical examination. According to the 2011 census, 490,000 individuals with gender dysphoria live in India. In many cases, the signs of gender dysphoria are there from an early age. However, social pressure will lead many children to suppress this aspect of themselves, leading to underlying unhappiness and anxiety in fear of rejection. Children pretend to be the 'boy' or 'girl' as it is expected of them. They are often bullied, ostracised and even killed, this stops them from being their true self. The degree of variation differs in individuals of gender minority from the birth-assigned gender (Elias Heino et al. 2020).

Development of Gender identity and sexuality reflects across physical, emotional, cognitive, social and emotional developmental markers of an individual. Each child is unique and grow at an individual pace. According to Kohlberg's Theory of gender identity development, young children learn to understand their gender and meaning from their everyday life experiences. As an individual matures, a better understanding of gender identity is gained, which stabilises and becomes consistent as per the person's appearance and activities. As Piaget's theory implies, gender identity develops by a child's day to day play with "gender-specific" toys, social interactions, and awareness of gender-related activities. Gender-based beliefs, attitudes and behaviours are influenced by biological factors like genes and hormones, environmental factors like the child's family, teachers, peers and media. These factors consciously or unconsciously reinforce stereotypical behaviours associated with them. Through this development process, a child is building an understanding of self-identity, identity, and labels associated with them without understanding the complexity of gender.

Gender Dysphoria in institutional care

The onset of puberty, often accompanied by specific anatomic dysphoria, distress evoked by the incongruence between the experienced gender identity and the developing secondary sex characteristics. The emotional pain and confusion were experienced when shifted from familiar surroundings to a new place, especially with pubertal physical changes. Living in institutions implies shared living spaces with hardly any personal space to understand and absorb the complex changes happening to her (gender the individual identifies now). The feelings of dysphoria and gender identity issues manifest differently, so different coping skills is very much needed to equip the child in this challenging transformation. The environmental factors such as the primary caregivers, peers, school and media influence the individual in building gender-based attitudes, behaviours and beliefs. The problems faced by the individual concerning the adjustments to make with self, the caregivers and peer need to be addressed. Lack of one-to-one relationship with the primary caregiver plays a significant role in the disturbed social and emotional development of children in institutional care (Johnson et al., 2006).

Case study

This case study attempts to throw light on the complex biological-physical, cognitive, social, and emotional developmental dimensions this child faces. This study may have essential recommendations for individuals with gender dysphoria living in orphanage homes represents a unique group with an appropriate environment and require special care. A provisional support system that encourages the individual self-understanding and better mind body connections through this self-evolution phase is the key to building self-esteem in these children. Enhanced self-esteem would go a long way in facing the consequences

associated with significant impairment in social, occupational, interpersonal, and other functioning areas.

P is 11 years old and was in a boys' home for the last ten years in Chennai's outskirts. She shifted to this institution a year ago when P started showing signs of breast development. The initial days were hard for her. First, she was displaced from the place she is familiar with – the caregivers, friends who were with her since the time she could remember. Then the most personal and vital part of an individual, her body which she had perceived to be a boy, was also not behaving as she thought it would. Ps friends (only two) recall that she refused to remove her dress while bathing for almost a month until she was slowly cajoled into doing so by her persistent caregiver. P gave in to this for the sake of hygiene. She continues to have issues with eating and sleeping. She prefers to eat in isolation instead of the dining hall like the other children do. There are days when she is crying in her sleep. These are a few instances of her daily activities affected. She cannot go to school as the earlier school's transfer certificate documented her as a boy. The institution and the school were unable to resolve this issue until legality is settled. In general, school and education have a significant role to play within the mental health care framework.

Adolescents are anxious about their future for when they will get out of the institution, and many of them might express their anxiety through aggression or other imperative challenging behaviours. Education gives children and young people the feeling that they have real opportunities, something tangible to build on. In the meantime, the child spends her time without any aim. Her best friends happen to be the elderly gatekeeper couple. Lately, she has started to study for half an hour, and to our wonder, she is right in essential reading and math, loves building blocks (which happens every day between 6 and 8 in the evening). The child still misses her grandpa, aunty and Akka (the caregivers in the earlier institution). She is slowly coming around and accepting changes within her and how the others relate to her, through constant emotional support by her caregivers and roommates.

Indeed, this must be happening to a few if not many children around the country and the world. The kind of support system in place to help children like this in institutions needs to be considered. The complex issues that arise with institutionalised children with gender dysphoria are always probed.

In the case of P, the complexity multi-folds in situations like these. Nevertheless, the home where the child presently resides, has a set of caregivers who have been working there for at least four to five years; the food, health and hygiene are monitored regularly by the health officials. Some volunteers support the staff by rendering their services. Despite all these things, the difference between these children (institutionalised) and the others are distinct.

Tim C et al. (2015), with 1019 applicants in which 637 were Male to female, showed a higher rate of dissatisfaction concerning overall body satisfaction and physical appearance than 382 females to male. The challenge the clinician's face is in offering insight to the patient with fragile personhood that is fluid, the feeling associated with it, how to make sense of all these, as changes faced by each individual is unique, equip the person with appropriate coping skills. There should be a framework of norms and values by which professionals dealing with a person's struggle with the involuntary disposition. The US Endocrine Society Clinical Practice Guideline (2009) recommends use of GnRH analogues

no later than Tanner stages 2-3 to suppress puberty in adolescents with a clear diagnosis of GID and introduction of cross-gender hormone treatment at 16 years of age.

Biological-physical changes occurring in the body is equally traumatic, if not more. The present study emphasises the psychosocial aspects of atypical gender development.

Biological-physical aspects

The number of children experiencing incongruency of gender identity with their phenotypes is very low. The individual gender identity is the chromosome's multifaceted expression, external and internal reproductive organs, hormones, and secondary sexual characteristics. The adult outcome varies from case to case and too uncertain to predict. According to the study done by Cohen-Kettenis (2001), only in 23% of these children, these incongruencies persists into adulthood, manifesting as transsexualism. The consequences associated with these trauma are not only the gender role expectations imposed upon by others but also an unconscious gender role identity by which individual identifies.

Psychological aspects

There is a higher prevalence of gender dysphoria in people with psychiatric illnesses such as schizophrenia (Ravi Philip Rajkumar 2014) and autism spectrum disorder (Derek Glidden et al 2015). The neuro-anatomical link with the topic under discussion needs to be researched. However, certain studies seek to disprove this hypothesis.

There is also growing evidence the childhood abuse, neglect, maltreatment, and physical or sexual abuse may be associated with Gender Dysphoria. Individuals reporting higher body dissatisfaction and Gender dysphoria have a worse prognosis in terms of mental health. And as mentioned above in epidemiology, individuals with atypical gender are found to have higher rates of depression, suicidal ideations, and substance use (Gender Dysphoria Article – StatPearls, 2020).

The cognitive domain is affected no less. Bandura's social cognitive theory emphasizes on the model of causation' that is influenced by three factors - behaviour (action patterns), a person (expectation, intentions, goals) and environment (modelling and reinforcements). Self-regulation is children and adults' ability to exert control over their attention, thoughts, and behaviours to achieve a goal. It must adapt emotions and actions according to the situational needs and internalise social standards and norms. The relative plasticity of self-regulation affects biological, behavioural, and contextual factors, like temperamental predispositions and aspects of the context influence a child's ability to regulate their thoughts, feelings, and behaviour (Megan M. McClelland et al. 2015). This study also sheds light on the crucial link of early experiences and genetic predisposition on self-regulation and later adult functioning in society. In that case, this child is in a delicate situation of being in institutional care where the first bonding with the long-time caregiver is severed. Her body is also behaving differently. Self-regulation encompasses skills such as inhibiting reflexive actions, paying attention and delaying gratification are bound to be affected.

Lily Durwood et al. (2017) reported that depression and anxiety is associated with low self-worth levels in children with gender dysphoria, where many psychopathological comorbidity cases are seen. Most common adverse effects that children who grow up in residential care experience include: developmental delays (van Ijzendoorn MH 2020), behavioural problems (Elebiary, Hoda & Behilak, Sahar & Kabbash, Ibrahim. 2010);

attachment disorders; lack of life skills and difficulty forming and maintaining healthy relationships. With all these factors to contend with, the child needs all the support; she can survive this identity crisis phase.

A well-equipped institution with dedicated staff could not be replaced with good parental care. It can cause harm to their neurobiological systems and significantly contribute to stress and the lowering of psychological well-being, cognitive skills, coping capacity, and emotional resilience.

Social aspects

People who experience the turmoil cannot correlate to their gender expression (Newman L 2012) when they need to identify within the traditional, rigid societal binary male or female roles, which may cause cultural stigmatisation. It can further result in relationship challenges with family and friends (Haldeman, Douglas. 2000) and lead to interpersonal conflicts and rejection from society. More awareness needs to be created about gender fluidity as a continuum from male to female rather than fixed binary norms. Society needs to reduce the burden of psychological problems created by the stigma associated with it.

Sexual orientation is different from gender. A transgender woman (biological male) may identify herself as heterosexual and still be sexually attracted to men and vice versa (Daniolos PT 2018). There is also growing evidence the childhood neglect, abuse, maltreatment, and physical or sexual abuse may be associated with Gender dysphoria.

Sometimes, due to greater exposure, social acceptance, and greater access to care, this population tends to expose before puberty, or they might present at late adolescence or adulthood. A strong support system in the form of necessary referrals for the patients should be provided.

During adolescence, bullying often has sexual content. Being involved in bullying as bully, victim or both has been associated with a range of adverse health issues. Transgender youth appear to face increased rates of bullying in comparison to their mainstream peers. A number of researches suggests that sexual minority youth report being bullied 2 times more than mainstream peers (Friedman et al., 2011; Abreu and Kenny, 2018; Kurki-Kangas et al., 2019; McKay et al., 2019). Transgender youth have been reported to experience more bullying related to gender or sexual orientation (Day et al., 2018) and with reference their size and weight (Bishop et al., 2020). In a UK-based clinical sample, almost 90% of transgender youth reported being bullied (Witcomb et al., 2019).

The association between being bullied and gender non-conformity may originate from heterosexism, a phenomenon of gender roles in society based on the presupposition that heterosexuality is a superior sexual orientation and the norm (Chesir-Teran, 2003; Toomey et al., 2012). Gender minority stress and resilience (GMSR) theory (Hendricks and Testa, 2012; Testa et al., 2015) posits that gender minority people experience external stress, such as discrimination and victimisation (such as being bullied). However, internal stress related to internalised transphobia and perceived stigma predisposes them to be constantly vigilant and anticipating discrimination. This factor may be due to the predisposed to the development of depressive or hostile attribution bias (Morris, 2007; American Psychological Association, n.d.), possibly leading to the perception of victimisation by peers when none was intended.

Planning appropriate intervention can only occur when seeing how the family understands gender variation and managing it within the family cultural framework. It is also essential that the child be supported in their overall social context and manage what may be a cultural "gap" between the family and mainstream social values.

As paediatricians, they are in a powerful position to promote health and positive outcomes for these children; however, only a few received any formal education or training to grappling with this increasingly common issue (de Vries AL 2012). Equally important is educating oneself on the diversity of gender and the available interventions for supporting them. Adopting affirming and supporting practices, such as making changes in the intake forms that allow for the patient's preferred name and feasible pronouns (and using they/them accordingly), is another critically important step for helping young persons' feel comfortable. Besides, medical professionals can advocate for their transgender patients' needs and rights in settings outside the clinic, such as home and school. (Olson J, Forbes C, et al. 2011)

Gender-nonconforming behaviour and gender expression in young children are typical, with gender-atypical behaviour reported in about 23% of boys and 39% of girls. (Sandberg DE et al., 1993). Many pre-pubertal gender-expansive children will experience what is often called a "social transition." It means that these children will change their name, pronouns, and external appearance to align with their affirmed gender. Generally, it involves the parents, school, and other institutions' efforts to agree on the child's support and care. These social transitions are completely reversible in case the child, with family support, later desires to transition back or forward to some other iteration of gender. However, experience has shown that not allowing such transitions can have serious negative consequences; that very few, if any, children later de-transition; and that early social transition can significantly reduce psychological distress and replace it with well-being. (Spack NP, Edwards-Leeper L, Feldman HA, et al. 2012).

It is essential to be mindful of how the child's transition will play out for the child at school. Youth undergoing treatment with puberty blockers and then deciding to begin cross-sex hormone therapy later in puberty can avoid undesirable changes such as breast development, voice changes, facial masculinisation, and body hair growth that may require expensive and often disappointing surgical procedures to correct. Earlier medical transitions are associated with more satisfactory outcomes and a greater facility to blend into the affirmed gender, resulting in less social stigma (de Vries AL et al. (2014), Cohen-Kettenis PT et al. (2008)).

Later in puberty, many adolescents are developing a more mature and focused sense of themselves and their life goals. Simultaneously, they may be experimenting with sexuality and substances, and conflicts with caregivers may be escalating. Transgender adolescents are experiencing all these changes and living in a body that may not fit the conception of their gender.

Clinical management of children with gender issues often involves integrated psychological, social and biological interventions. In the current state of knowledge, physical interventions are used cautiously and following a comprehensive assessment. Providing parents and families with a clear, planned and staged treatment model is essential and may help them deal with and ameliorate the child's distress. General paediatricians are often the first contact within the healthcare system for gender-nonconforming/gender-expansive and transgender

children and teenagers. Such providers must be familiar with the psychological and medical approaches to care for this population.

Regulatory aspects of Government and legislation

Atypical gender development is a problem of personal health and a public problem because sufferers are often exposed to discrimination, abuse and violence, and each act of discrimination, abuse, and violence is a public issue.

World Health Organisation has reclassified gender dysphoria in terms of "sexual health" and has eliminated it from its mental disorders list. The delisting of trans-sexuality from a list of mental health or behavioural disorders took a long time for the scientific communities to agree upon. (WHO) eliminates gender dysphoria as a mental disorder. The government makes a few provisions. In essence, Tamil Nadu has made provisions for changing transgender (TG) people's birth name and gender in the official gazette and official identity documents either after realising their gender identity or undergoing sex reassignment surgeries (SRS).

Moreover, the Supreme Court of India's landmark Judgement on Apr 15, 2014, has identified TG people as the third gender and has ordered the government to provide transgender individuals with quotas in education and jobs in line with other minorities, as well as essential amenities. There is a long way to go before people with gender dysphoria are accepted in society without stigma. This case highlights the critical issues faced by clinicians dealing with gender dysphoria. There has to be attentive and careful, finding the right balance between enhancing children's hopes and dreams and providing them with accessible opportunities. It should include using the bathroom that aligns with their gender identity, vocational skills, and intelligent solutions compatible with their capacities, the job-market demand.

The prevalence and predictors of persistence among children with gender dysphoria has to be assessed by the authorities and examine the outcomes of a gender-affirming model (the process by which individuals affirm their gender identity through social, peer, familial, medical, and legal interactions) vs other approaches to pre-pubertal youth care. The impact and implications of social transition in childhood has to be investigated. Significant gaps in knowledge exist in nearly all aspects of gender variance, gender dysphoria and transgender experiences of children, adolescents and young adults.

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